H.R. 1

IMPLEMENTATION JOURNEY MAP

NATIONAL COUNCIL
for Mental Wellbeing

IMPLEMENTATION JOURNEY MAP

As states move to implement the Medicaid provisions of H.R. 1, behavioral health providers face both operational challenges and critical opportunities to shape the path forward. This journey map is designed to equip National Council for Mental Wellbeing members with clear, actionable guidance on the policy changes ahead, the roles of key stakeholders, and the opportunities that matter most for engagement. By proactively collaborating with state officials, leveraging community partnerships, and elevating the needs of people with mental health and substance use challenges, providers can help ensure implementation decisions preserve and strengthen access to care.

How to Use This Resource

This document outlines the key changes to Medicaid under H.R. 1, organized by implementation year. Each section contains:

- A summary of the year's implementation dates
- Key engagement opportunities for that year. Please note, many opportunities to engage happen before the changes become effective. You can also take action now by evaluating the Proactive Practice Considerations for your organization.

A deeper dive describing key provisions can be found in the appendix organized by the year they become effective.

Table of Contents

Proactive Practice Considerations **2**

Data Collection and Story Banking **2**

2025 ..... **3**

Summary of Implementation Dates in 2025 ..... *4*
Key Opportunities to Engage in 2025 ..... *5*

2026 ..... **6**

Summary of Implementation Dates in 2026 ..... *7*
Key Opportunities to Engage in 2026 ..... *8*

2027 ..... **9**

Summary of Implementation Dates in 2027 ..... *10*
Key Opportunities to Engage in 2027 ..... *11*

2028 ..... **12**

Summary of Implementation Dates in 2028 ..... *13*
Key Opportunities to Engage in 2028 ..... *14*

2029 and Beyond **15**

Summary of Implementation Dates in 2029 and Beyond *6*
Key Opportunities to Engage in 2029 and Beyond *17*

Final Considerations **18**

Appendix **19**

Deeper Dive: Provisions Effective 2025–2029 and Beyond *19*

Proactive Practice Considerations

- Look to plan education, outreach, and enrollee evaluation for other eligibility pathways, coverage, and benefits.
- Are there partners you can work with to increase universal screenings?
- Are there systems needed for proactive disability determination?
- Are systems or technology needed to track and support timely renewal determination process?
- Are there costs you can control now? Consider review of IT infrastructure or contracts for efficiency.
- Are there opportunities to develop innovative partnerships?
- Are there local partners that need to be informed and could be key advocates, such as law enforcement?
- Look to identify key places where you could work with the state to minimize administrative burden and to maximize exemptions (i.e., where broad definitions are possible).
- Begin collecting data on impact now to establish a baseline and evaluate as more changes come into effect.

Data Collection and Story Banking

Now and over time, it will be key to collect stories and data on the impacts of H.R. 1 to establish a general baseline and evaluate its impact over time. Such data and stories will be essential to continued advocacy. Data collection could include:

- Uncompensated care furnished
- Waitlists due to capacity
- Number of people turned away/not able to be seen due to capacity
- Amount of staff reductions to remain operational
- Amount of emergency care (or higher level of care) needed to identify trends
- Trends in increased patient acuity
- State reimbursement rates

Consider building a repository of patient, provider and community stories illustrating the impact of Medicaid coverage losses on behavioral health service access or clinic operations.

2025

Summary of Implementation Dates in 2025

START HERE

MAY 1

- Cutoff date for permissible provider tax classes.
- Deadline for written prior approval, or a good faith effort to receive such approval, for state-directed payments (SDPs) to nonrural hospitals in order to be grandfathered.

JULY 4

- Current provider tax rate is frozen in place on this date, and a moratorium is imposed on new provider taxes.
- Provider tax criteria for being considered generally redistributive is modified. States with tax waivers in place must modify them, as needed, to comply.
- Deadline for written prior approval, or a good faith effort to receive such approval, for SDPs to rural hospitals in order to be grandfathered, as well as for SDPs for which a preprint was submitted.
- New SDPs are capped at 100% of the Medicare rate in states that have expanded Medicaid and 110% of the Medicare rate in non-expansion states.

OCT. 1

- During the one-year period beginning the first quarter this bill is enacted, there will be a prohibition on the expenditure of federal funds, either as direct spending or to a state Medicaid plan, to a "prohibited entity" for items and services furnished.

DEC. 31

- Deadline for Centers for Medicare and Medicaid Services (CMS) to issue guidance related to eligibility redeterminations.

Key Opportunities to Engage in 2025

Rural Health Transformation (RHT) Program engagement with states: The National Council for Mental Wellbeing has shared a template letter with Association Executives to support engagement in state efforts on the RHT Program application. The National Council has also hosted a webinar with more information on the RHT Program (view slides here and recording here).

Eligibility redetermination rule to be issued in December 2025:

- Stay tuned for communications and resources from the National Council on this rule. The Department of Health and Human Services' (HHS) unified agenda had both SDPs and eligibility redeterminations scheduled to be released by CMS in October, but that was delayed following the shutdown.
- Clarification will be needed on acceptable data for verification and additional information on funding provided to meet these requirements.
- States may need assistance with hiring eligibility workers/call center staff, technical assistance, upgrading eligibility and enrollment systems, public education campaigns to reduce churn and hard-to-reach enrollees, distributing multilingual information, and partnering with community-based organizations to conduct direct outreach.

Community engagement requirements: While these requirements won't come into effect until 2027, now is the time to work with your state and partners in the field to suggest ideas and solutions that minimize burden and maximize exemptions provided in statute.

- On Dec. 8, CMS issued an informational bulletin preceding rulemaking on the new community engagement requirements.
- Read a memo providing analysis of the guidance.

Provider tax changes: States may need to pass legislation and/or engage in rulemaking to bring existing provider taxes into compliance with this provision. Many states also likely will need to adjust budgets to make up for the revenue shortfall caused by this provision and may call special sessions to facilitate this. States may look to respond to reduced revenues by:

- Expanding non-Medicaid revenue streams (e.g., commercial payers, grants).
- Developing new integrated care partnerships to share risk and savings.
- Exploring philanthropic/foundation support to stabilize operations where possible.
- Demonstrating the return on investment of Certified Community Behavioral Health Clinic (CCBHC) services to capitalize on other funding sources.

Initiate data collection, story banking and proactive practices, where appropriate.

2026

Summary of Implementation Dates in 2026

START HERE

JAN. 1

- Sunsets the increased Federal Medical Assistance Percentage (FMAP) for states that had not yet expended all amounts for the Medicaid expansion population.
- Medicare Physician Fee Schedule conversion factor increases 2%.
- Repeals eligibility for noncitizens to receive premium assistance tax credits.
- Implements premium tax credit ineligibility for individuals enrolling in a Marketplace plan due to Medicaid eligibility determinations.
- Implements recapture eligibility for all excess advance payments to individuals eligible for advance premium tax credits.
- Individuals enrolled in high-deductible health plans are now allowed to enroll in direct primary care services.
- All bronze and catastrophic health plans are categorized as high-deductible health plans for the purposes of health savings account contributions.

JULY 4

- Deadline for Social Security commissioner to review citizenship/immigration status of individuals enrolled in Medicare.

JUNE 1

- Deadline for HHS to issue an interim final rule on Medicaid work requirements.

OCT. 1

- Implementation date for citizenship/immigration status requirements for Medicaid and CHIP benefits.
- Implementation date for limit on FMAP for emergency Medicaid services offered to noncitizens.
- Replaces the current 6% revenue threshold cap ("safe harbor threshold") for existing provider taxes with the applicable percentage of net patient revenue attributable to the taxed class as in effect on July 4, 2025.

Key Opportunities to Engage in 2026

Community engagement requirements: CMS must issue an interim final rule to states on initial implementation by June 1, however the agency has indicated it may issue separate guidance sooner. In the meantime, there is opportunity to engage states to urge them to maximize exemptions and minimize burden and develop solutions to meet state-specific need.

Prior to 2027, it will be key to engage at both federal and state levels, where applicable, to clarify terms and implementation details to minimize burden for patients and providers and maximize exemptions. If needed, engage with your state regarding the potential for a good faith exemption.

States will need to:

- Establish or significantly upgrade systems to track and verify hours of employment or other qualifying activities.
- Coordinate with labor departments, education institutions and workforce development agencies.
- Develop infrastructure, train staff and run public education campaigns.
- Provider organizations will need to:
- Ramp up eligibility assistance for clients to help them comply with work reporting requirements (e.g., submitting documentation, applying for exemptions).
- Provide training on the new rules and workflows.
- Ensure systems are in place for anyone who meets exemption requirements to be identified and/or seek the appropriate eligibility pathway.

Continue collecting data and stories, including on implementation of proactive practices, where appropriate.

2027

Summary of Implementation Dates in 2027

START HERE

JAN. 1

- State Medicaid and CHIP plans must implement a process to regularly obtain addresses from enrollees, as well as check deceased status.
- Medicaid managed care entities or providers of prepaid inpatient/ambulatory health plans must provide their beneficiaries' address information to states.
- State Medicaid plans must implement six-month eligibility redeterminations for individuals in the expansion population.
- Retroactive coverage is limited to two months before the application for benefits for the non-expansion Medicaid population and one month prior for the expansion population.
- Implements budget neutrality requirements for Section 1115 demonstration waivers.
- Medicaid work requirements for non-exempted individuals go into effect.

JAN. 4

- Implements citizenship/immigration requirements for Medicare enrollees.

OCT. 1

- For expansion states with existing provider taxes, beginning of provider tax safe harbor threshold phasedown; limit reduced to 5.5%.

Key Opportunities to Engage in 2027

Duplicate enrollment: States will likely engage in rulemaking to establish processes for obtaining enrollee data to submit to CMS. Consider engaging in any rulemaking process at the state level to ensure that the processes developed account for any relevant limitations or considerations members may encounter in providing data, including HIPAA/privacy issues.

Retroactive coverage: Provider organizations may need to:

- Adjust their administrative, clinical and financial systems to ensure compliance and maintain access to reimbursement for eligible services.
- Document initial contact and service dates meticulously, as they can prove that care was provided within applicable windows.
- Track whether members are part of the expansion population, as retroactive coverage windows will be different (one month for expansion enrollees vs. two months for non-expansion enrollees). (This is also applicable to several other provisions.)
- Update billing systems to flag clients based on whether they are in the expansion or non-expansion group, to ensure claims fall within the correct retroactive time frames.
- Track and audit service dates closely to ensure claims are submitted only for eligible retroactive periods (i.e., no more than one or two months before the application date).

2028

Summary of Implementation Dates in 2028

START HERE

JAN. 1

- States must implement death verification for provider enrollment, reenrollment or revalidation of enrollment.
- Home equity limit for long-term care service eligibility is revised.
- All existing SDPs not in compliance with the allowable rate (100% of the Medicare rate in expansion states and 110% in non-expansion states) are reduced by 10 percentage points.
- Drugs with more than one orphan drug indication are exempted from the Medicare Drug Price Negotiation Program.
- Implements pre-enrollment eligibility verification requirements for premium tax credits.

MARCH 31

- CMS administrator must assess whether funds remain in the RHT Program fund for FY28.

JULY 1

- Allows states to apply for a stand-alone waiver to cover home- and community-based services without requiring institutional level-of-care determinations. Approved waivers start with an initial three-year term and, upon request by the state, can be renewed in five-year extension periods unless the state is noncompliant.

OCT. 1

- For expansion states, provider tax rate safe harbor threshold is reduced to 5%.
- Enrollment fees and premiums for Medicaid expansion population are eliminated.
- Medicaid cost sharing for certain services, prescription drugs and overall services is limited.

Key Opportunities to Engage in 2028

State-directed payments: The bill requires CMS to revisit the 2024 Medicaid managed care rule that finalized the average commercial rate as the upper payment limit on the amount of directed payments a state can make. The secretary will need to prohibit expansion states from instituting new SDPs that exceed Medicare rates and non-expansion states from instituting new SDPs that exceed 110% of Medicare rates.

- This revised rule is expected to be released in fall 2025, and there may be a notice and comment period to follow. CMS has issued interim guidance.

Cost sharing: States will need to determine what level of cost sharing should be charged, in addition to other details. States also likely will vary in what falls under mental health or substance use exceptions, and these definitions may be provided through state rulemaking.

- Consider engagement to clarify if cost sharing applies to medications provided at community mental health and substance use provider organizations.

2029
AND BEYOND

Summary of Implementation Dates in 2029 and Beyond

START HERE

OCT. 1, 2029

- For expansion states, provider tax safe harbor threshold is reduced to 4.5%.
- HHS must reduce federal financial participation to states for payment errors related to improper payments or overpayments.
- State Medicaid and CHIP plans must begin collecting enrollees' and applicants' Social Security numbers and other information designated by the secretary, to ensure individuals are not enrolled in multiple state plans.

OCT. 1, 2030

- For expansion states, provider tax rate safe harbor threshold is reduced to 4%.

OCT. 1, 2031

- For expansion states, provider tax rate safe harbor threshold is reduced to 3.5%.

SEPT. 30, 2034

- Delay on implementation, administration and enforcement of the following rules is lifted:
  - "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" (88 F.R. 65230)
  - "Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes" (89 F.R. 22780)
  - "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (89 F.R. 40876)

Key Opportunities to Engage in 2029 and Beyond

- **Continue collecting** data and stories and share with policymakers and key stakeholders, where appropriate.
- **Further action** opportunities will be updated as developments progress.

FINAL CONSIDERATIONS

The steps contained in this roadmap were designed to help our members navigate an emerging new landscape that holds both challenges and opportunities. As developments warrant, we will keep you apprised of relevant updates and additional opportunities to engage. Together, we can advance a more sustainable Medicaid system that protects coverage and promotes the wellbeing of the communities we serve.

If you have any questions, contact us at policy@thenationalcouncil.org.

Useful Resources

- See our summary of key H.R. 1 Medicaid provisions.
- **How do you know if you are in an expansion state?** See KFF's map of states' Medicaid expansion decisions.
- **What's the expansion population?** Adults 19 to 64 who have incomes less than 138% of the Federal Poverty Level.
- **CMS Summary of Medicaid Provisions:** Additional guidance from the implementing agency, released Nov. 18.
- **Modern Medicaid Alliance Dashboard:** A one-stop shop for the latest Medicaid enrollment, polling data and funding info.
- **KFF Work Requirement Implementation Tracker:** This interactive tracker monitors key data and policies.

APPENDIX

Deeper Dive: Provisions Effective 2025

Provider taxes

Under current law, states are permitted to impose provider taxes on health care providers to help finance the nonfederal share of Medicaid spending. Federal law and regulations set strict requirements on these taxes to prevent improper use of federal matching funds.

Effective July 4, 2025, H.R. 1 freezes the applicable percentage of revenue attributable to the taxed class at what was in effect on the date of enactment.

- **State impact:** All states except Alaska use provider taxes to help finance their Medicaid programs.

Waiver of uniform Medicaid tax requirement: H.R. 1 prohibits waivers for certain tax structures that would impose lower rates on providers with less Medicaid volume, or higher rates on those with more. It modifies the criteria under which a tax is not considered generally redistributive, within a permissible class. It requires states with tax waivers in place as of the date of enactment to modify them, as needed, to comply with these requirements.

- **State impact:** This will likely impact a small number of states using such tax arrangements, including **California, New York, Michigan, Massachusetts, Illinois, Ohio and West Virginia**.

Prohibition on Medicaid and CHIP enrollment rules

Effective July 4, 2025, this provision delays the implementation of the CMS two-part final rule (September 2023; March 2024) updating eligibility determination, enrollment and renewal processes for Medicaid and the Children's Health Insurance Program (CHIP).

Policies finalized under the rules sought to streamline the Medicaid application process and simplify enrollment for eligible individuals who may otherwise opt out of the program due to the burdensome application process. The bill specifically delays implementation until Sept. 30, 2034.

Rural Health Transformation Program applications

States seeking funds were required to submit a one-time "rural health transformation" application **by Nov. 5, 2025**. CMS has announced that all 50 states have submitted applications (the program was not open to territories and the District of Columbia). Applications must detail how the state will use money to support at least three of the 10 program areas (one of which includes improving access to services for opioid use disorder, substance use disorder and mental health). CMS must approve or deny applications **by Dec. 31, 2025**.

The RHT Program website is live and features descriptions, strategic goals and timelines of the program.

Eligibility redeterminations

- CMS must issue guidance related to implementation by **Dec. 31, 2025**.
- States are required to conduct eligibility redeterminations for the expansion population every six months, down from the current 12-month requirement. (**effective Jan. 1, 2027**).
- The bill appropriates $76 million to CMS for FY26 to carry out this provision.

Deeper Dive: Provisions Effective 2026

RHT Program distribution begins

The RHT Program provides a $50 billion relief fund for rural providers. It will distribute $10 billion per year from 2026 to 2030.

Half of the $50 billion will be divided equally among all approved states — CMS has confirmed this will total $100 million per state — while CMS will distribute 40% of the remaining funds based on factors named in the bill.

Community engagement requirements

- HHS must issue an interim final rule with guidance to states on initial implementation **by June 1, 2026**.
- The bill provides HHS with the authority to exempt a state from compliance with work requirements if it demonstrates a good faith effort to comply with the requirements. The exemption would last **until Dec. 31, 2028**.
- CMS will provide $100 million in grants on a per capita basis to states, and then another $100 million evenly distributed among states, for implementing the requirements of the bill.

Medicaid eligibility for qualified "aliens"

Currently, certain qualified noncitizens are permitted Medicaid coverage if they meet other conditions of eligibility. **Effective Oct. 1, 2026**, this provision narrows the scope of Medicaid and CHIP eligibility for immigrants and prohibits federal financial participation for such payments, unless certain criteria are met, which include that the individual is:

- A resident of one of the 50 states, the District of Columbia or a U.S. territory, and one of the following:
  - A citizen or national of the U.S.
  - An alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act, excluding alien visitors, tourists, diplomats and certain foreign students
  - Certain aliens who have been granted the status of Cuban and Haitian entrant
  - An individual who is lawfully residing under the Compacts of Free Association

Expansion FMAP for emergency Medicaid

Previously, the law required states to provide Medicaid coverage to certain noncitizens for emergency medical services, a concept known as "emergency Medicaid."

Effective Oct. 1, 2026, this provision narrows emergency Medicaid by limiting the FMAP of these services to no more than a state's traditional FMAP, preventing states from claiming the 90% FMAP for emergency services provided to nonpermanent resident aliens who would qualify for Medicaid under the expansion.

Sunsetting temporary FMAP increase

Effective Jan. 1, 2026, H.R. 1 sunsets the temporary 5% FMAP increase for states that have not expanded Medicaid. States can receive the temporary FMAP only if they begin to expend amounts for all individuals in the expansion population prior to Jan. 1, 2026.

Deeper Dive: Provisions Effective 2027

Community engagement requirements

Effective Jan. 1, 2027, H.R. 1 requires expansion enrollees to complete at least 80 hours of work or qualifying activities per month. Other qualifying activities can include community service, educational programs or a combination.

Exemptions are included for:

- Individuals with a substance use disorder or "disabling mental disorder"
- Individuals in a "drug addiction or alcoholic treatment or rehabilitation program" (not including private-sector programs/facilities)
- Full list of exemptions (source: State Health & Value Strategies)

States must verify, in a manner determined by HHS, that an enrollee has met the work requirements during the individual's regularly scheduled eligibility redetermination (at least every six months for expansion enrollees).

Eligibility redeterminations

Previously, states were generally not permitted to redetermine Medicaid eligibility more than once every 12 months. **Effective Jan. 1, 2027**, H.R. 1 requires states to conduct eligibility redeterminations for the expansion population every six months. This requirement does not apply for an individual who is "an Indian or an Urban Indian[,] a California Indian [or who] has otherwise been determined eligible as an Indian for the Indian Health Service."

Retroactive coverage

Under current law, Medicaid enrollees may receive retroactive coverage of services that would have otherwise been covered under the program for up to three months prior to the individual's application date, if that the individual would have been eligible for Medicaid during that time.

Effective Jan. 1, 2027, H.R. 1 limits retroactive coverage for medical assistance for the expansion population to one month before the individual made an application for benefits, and limits it to two months for the non-expansion population.

Reducing duplicate enrollment

Effective Jan. 1, 2027, states must develop a process for regularly obtaining enrollees' address information using data sources including mail records and managed care organization data.

In addition to this provision, CMS recently announced it will partner with states on initiatives aimed at reducing three types of duplicate enrollment:

- Individuals enrolled in two or more Medicaid programs
- Individuals enrolled in Medicaid or CHIP and a subsidized Federally-facilitated Exchange plan
- Individuals enrolled in Medicaid or CHIP and a subsidized State-based Exchange plan

Disenrollment of deceased individuals

Effective Jan. 1, 2027, states must begin reviewing the Death Master File at least quarterly to check if any individuals enrolled in the state Medicaid program are deceased.

If a state discovers that an individual enrolled in Medicaid is deceased, it is required to disenroll the individual from Medicaid and discontinue any Medicaid payments made on behalf of the deceased individual after the death of the individual. Also under this provision, a state must immediately reenroll an individual, retroactive to the date of disenrollment, whom the state determines was misidentified as deceased.

Budget neutrality for Section 1115 demonstration projects

Effective Jan. 1, 2027, the bill codifies a long-observed policy of Medicaid budget neutrality for Section 1115 demonstrations by explicitly adding it to federal statute and preventing CMS from approving or renewing a waiver unless the chief CMS actuary certifies that federal spending under the waiver would not be higher than it would be in the absence of the waiver.

This could result in preventing approval of some new waivers and renewal of some existing waivers, if the CMS actuary calculates budget neutrality more strictly than CMS' current practice.

Provider taxes

Under current law, states are permitted to impose provider taxes on health care providers to help finance the nonfederal share of Medicaid spending. Federal law and regulations set strict requirements on these taxes to prevent improper leveraging of federal matching funds.

- **For expansion states:** Begins phasedown of the safe harbor threshold from the current maximum of 6% to 3.5% over the course of five fiscal years, beginning in FY28 (Oct. 1, 2027).
- **Effective Oct. 1, 2027:** Reduces the current 6% provider tax safe harbor threshold to 5.5%.
- CMS has issued preliminary guidance for states regarding the new provider tax requirements in H.R. 1.

Deeper Dive: Provisions Effective 2028

State-directed payments

- H.R. 1 lowers the total payment rate in expansion states for SDPs to hospital services, professional services at academic medical centers and nursing facility services to:
  - 100% of the published Medicare rate for expansion states
  - 110% of the published Medicare rate for non-expansion states
- It grandfathers existing SDPs up to the average commercial rate, if written approval is made before May 1, 2025, or a payment for a rural hospital with prior approval made by the date of enactment.
- Phasedown begins Jan. 1, 2028, proceeding by 10 percentage points annually until the applicable cap is met.
- On Sept. 9, 2025, CMS issued a dear colleague letter on preliminary guidance for SDPs in Medicaid managed care while the agency works on a final rule.

Screening for deceased providers

Effective Jan. 1, 2028, H.R. 1 requires states to, at the time of enrollment or reenrollment, as well as on at least a quarterly basis, check the Death Master File to determine whether a Medicaid provider is deceased.

Cost sharing requirements

Effective Oct. 1, 2028, H.R. 1 requires cost sharing greater than $0 up to $35 per service for the expansion population. The total aggregate amount of cost sharing that a state may impose for all individuals in a family may not exceed 5% of the family income, as applied on a quarterly or monthly basis.

The law includes exceptions for primary care, mental health and substance use disorder services and specifically exempts services furnished by CCBHCs, Federally Qualified Health Centers and Rural Health Clinics.

Deeper Dive: Provisions Effective 2029 and Beyond

Reducing duplicate enrollment

Effective Oct. 1, 2029, states must begin submitting enrollee data, such as Social Security numbers and other information deemed necessary by HHS, monthly to a new federal system designed to detect duplicate enrollment. States will be required to act on matches identified by the system and disenroll individuals who no longer reside in the state, subject to exceptions.

H.R. 1 directs HHS to create a federal system to receive enrollee data from states and notify them of potential matches indicating duplicate enrollment. The system must be developed as to provide for the receipt of information described above and to notify the state at least every month whether an individual enrolled or is seeking to enroll in another state.

State penalties for improper payments

Current law directs CMS to recoup federal funds for erroneous payments made for ineligible individuals and overpayments for eligible individuals if the state's eligibility error rate exceeds 3%. CMS may waive the recoupment if the Medicaid agency demonstrates a good faith effort to get below the 3% allowable threshold.

Effective Oct. 1, 2029, H.R. 1 requires HHS to reduce federal financial participation to states for payment errors related to improper payments to ineligible individuals or overpayments to eligible individuals. This would effectively eliminate the existing good faith waiver.

To reduce erroneous payment amounts (especially for those who are later determined to be ineligible) and avoid the risk of large funding penalties, this could lead to states adding more red tape and prioritizing denials and disenrollments over enrollment and renewals. This requirement, particularly given the reduced retroactive eligibility period, is likely to lead to increase financial burden on providers.